Crystal Seman — PHONE (HOME) 858-3904 — PHONE (WORK) ∅

783 Gopher Ridge Rd — Samson, Al 36477 — EMPLOYER ∅ — SS# 28[illegible]150086

BIRTHDATE 3-9-70 — AGE 33 — SEX F — BROUGHT BY ☑ SELF ☐ RELATIVE ☐ AMBULANCE ☐ POLICE ☐ OTHER

GUARANTOR NAME (LAST, FIRST, MIDDLE) — PHONE (HOME) — PHONE (WORK)

MAILING ADDRESS — CITY — STATE — ZIP — EMPLOYER — SS#

Injury @ Piggly Wiggly - Florala — Marcie - Food Giant Supermarket 120 Industrial Drive Sikeston, MO 63801 Phone 573-471-3500

FINANCIAL CLASS: ☐
1. BC/BS 2. MEDICARE 3. COMMERCIAL
4. SELF-PAY 5. MEDICAID 6. WORKMAN'S COMP.
7. M/C-MCAID 8. OTHER

INSURANCE INFORMATION

NAME OF INS. CO. ______ CONTRACT # ______ GROUP # ______
INSURED THROUGH ______ RELATIONSHIP ______ PHONE ______

NURSING ASSESSMENT:
Hurt (R) wrist on shopping cart @ Piggly Wiggly yesterday - Able to sign name (c) (R) hand - Sez certain movements painful lifting heavy object painful (c) (R) wrist

R.N. SIGNATURE SAdams RN

CONDITION ON ADMISSION: Stable
LAST TETANUS: UTD
ROUTINE MEDS: ∅
ALLERGIES: ∅

PHYSICIAN'S REPORT:
[illegible handwriting]

T 98[3] P 84 R 18 BP 152/96 TIME 1200
T P R BP TIME
T P R BP TIME

MEDS GIVEN | TIME--SITE--ROUTE--SIGNATURE
wrist/forearm splint SAB

DIAGNOSIS:
[illegible] R wrist

PHYSICIAN'S ORDERS:
[illegible handwriting]

TREATMENTS DONE | TIME – SIGN.

BRIEF HISTORY: R wrist Pain

DISPOSITION OF CASE ☑ DISMISSED ☐ ADMITTED ☐ TRANSFERRED
HOW DISMISSED ☑ AMBULATORY ☐ WHEELCHAIR ☐ STRETCHER ☐ OTHER
ACCOMPANIED BY: ☑ SELF ☐ RELATIVE ☐ POLICE ☐ OTHER

CONDITION ON DISMISSAL: Stable
TIME OUT 1245

CHARGES
(DOES NOT INCLUDE ATTENDING PHYSICIAN'S FEE)

☐ EMERGENCY $ ______
☐ CENTRAL SUPPLY ______
☐ LABORATORY ______
☐ X-RAY ______
☐ PHARMACY ______
☐ OXYGEN ______
☐ LOCAL ANES. ______
☐ OTHER ______
TOTAL $ ______

PHYSICIAN'S FEE $
BILL TO
ADDRESS
BILLED ☐ PAID ☐ DATE

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

I, THE UNDERSIGNED, A PATIENT IN THE ABOVE-NAMED HOSPITAL, HEREBY AUTHORIZE THE ATTENDING PHYSICIAN (AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS) TO ADMINISTER SUCH TREATMENT AS IS NECESSARY, WITH THE EXCEPTION OF ______

CS — PATIENT SIGNATURE OR RESPONSIBLE PARTY

AUTHORIZATION FOR RELEASE OF INFORMATION

I, THE ABOVE-NAMED PATIENT AT THE ABOVE-NAMED FACILITY, HEREBY AUTHORIZE THE SAID FACILITY TO FURNISH SUCH PROFESSIONAL INFORMATION, IN ACCORDANCE WITH THE POLICY OF THE FACILITY, AS MAY BE NECESSARY FOR THE COMPLETION OF MY PATIENT CARE INSURANCE CLAIMS BY THE ABOVE-NAMED THIRD PARTY (HEALTH INSURANCE CARRIER) FROM THE MEDICAL RECORDS COMPILED DURING MY PRESENT PATIENT STAY AND HEREBY RELEASE THE SAID FACILITY FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION REQUESTED.

CS — PATIENT SIGNATURE OR RESPONSIBLE PARTY

AUTHORIZATION OF HOSPITAL BENEFITS/GUARANTEE OF PAYMENT

IN CONSIDERATION FOR SERVICE RENDERED OR TO BE RENDERED BY THE ABOVE-NAMED HOSPITAL, I HEREBY ASSIGN TO SAID HOSPITAL THE BENEFITS DUE ME COVERING HOSPITAL EXPENSE UNDER THE ABOVE-NAMED INSURANCE POLICY INSOFAR AS THEY ARE NECESSARY TO COVER SUCH EXPENSE.
I AGREE THAT, SHOULD THE AMOUNT BE INSUFFICIENT TO COVER THE ENTIRE HOSPITAL EXPENSE, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE, AND THAT IF THE NATURE OF THE DISABILITY BE SUCH THAT IT IS NOT COVERED BY THE SAID POLICY, I WILL BE RESPONSIBLE TO THE HOSPITAL FOR PAYMENT OF THE ENTIRE BILL.
AGREEMENT TO PAY: THE UNDERSIGNED ACCEPTS THE FEE CHARGED AS A LAWFUL DEBT AND PROMISES TO PAY SAID FEE AS OUTLINED ABOVE INCLUDING THE COST FOR COLLECTION, ATTORNEY FEES, AND COURT COSTS IF SUCH BE NECESSARY, WAIVING NOW AND FOREVER THE RIGHT TO CLAIM EXEMPTION UNDER THE CONSTITUTION AND LAWS OF THE STATE OF ALABAMA, OR ANY OTHER STATE.

CS — PATIENT SIGNATURE OR RESPONSIBLE PARTY

PLAINTIFF'S EXHIBIT 16a
Blumberg No. 5113

INSTRUCTIONS TO PATIENT: See FMD for followup

Crystal Seaman — PATIENT SIGNATURE — DATE — TIME — PHYSICIAN'S SIGNATURE

MEDICAL RECORDS — FORM

P.O. Box 189 • 24273 Fifth Avenue • Florala, Alabama 442
(334) 858-3287

FOR Crystal Serna

ADDRESS ______________________ DATE 4/26/03

R

Medrol Dose Pk.
#1
As Directed

Augment ES. #15 T 98L

______________________ M.D.
PRODUCT SELECTION PERMITTED

REFILL ________ TIMES ______________________ M.D.
DISPENSE AS WRITTEN

MEDICAID ____________ ACS No. ____________ DEA No. ____________

PLAINTIFF'S EXHIBIT 16b

PATIENT NAME (LAST, FIRST, MIDDLE)	REV CAT	BASE C/S	DUE DATE YY MM DD	ADMIT CLERK	DATE	TIME
[illegible] Samon					9/26	

GUARANTOR NAME (LAST, FIRST, MIDDLE)	STREET ADDRESS	CITY STATE	ZIP	TELEPHONE NO.

SPRAIN, FRACTURE & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering, after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast - this should be done often if it does not cause pain.
- ☐ If the part swells anyway, or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - If you are tense the problem will only be worse.
- ☐ Gentle but firm message will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger than the other.
- ☐ Complaints of double vision.
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next day by Radiology Dept, if any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up copies of your X-rays and take them with you to the doctor's office.
Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and to help speed wound healing.
- ☐ Despite the greatest care any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____
- ☐ Tetanus Toxoid given _____ 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-5 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily, 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is no vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following clear liquids: Coke, Gingerale, 7-up, weak tea, Gatorade or Jello water. If patient is hungry you may add 1 teaspoon of sugar to each ounce of fluid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occurred, the amount may be slowly increased.
- ☐ Using no more than 1/2 glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed / may go to bathroom.
- ☐ Use vaporizer.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours.
- ☐ Avoid any use of injured part.
- ☐ You need not necessarily limit activity.
- ☐ Fill prescriptions given to you from Emergency Dept. and take as directed.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to veterinarian for observation.
- ☐ If the owner should refuse to take the animal to the veterinarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS Pt. conditions worsens go to nearest ER

I hereby acknowledge receipt of all instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT'S SIGNATURE	NURSE'S SIGNATURE	PHYSICIAN'S SIGNATURE
[illegible]	Sherry Adams RN	[illegible]

SCHOOL AND WORK EXCUSE PATIENT NAME _____ DATE _____

- ☐ No work for _____ days
- ☐ Light duty for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

PHYSICIAN'S SIGNATURE [illegible]

Blumberg No. 5113

PLAINTIFF'S EXHIBIT 16C

FL~RALA MEMORIAL HOSPITAL
P.O. Box 189 • 24273 Fifth Avenue • Florala, Alabama 36442
(334) 858-3287

PROMISSORY NOTE AND AGREEMENT

Florala, Alabama

$ Pending   4/26/03, 20____

The below signed party understands that they are responsible for any charges denied by the insurance company.

For and in consideration of services rendered to

____

I/We Crystal Sonran ______________ promise to pay to the order of FLORALA MEMORIAL HOSPITAL payable at FLORALA MEMORIAL HOSPITAL, in the City of Florala, State of Alabama, the sum of:

($ Pending), payable ten (10) days after date of discharge, without grace, with interest at eight (8) percent per annum.

Acceptance by the holder of part payment hereof or of scheduled periodic payments shall not constitute a waiver of the right to demand payment in full on the due date hereof. The payee named herein does not waive any right to establish or enforce any liens granted or authorized under the Constitution and laws of the State of Alabama or any other state.

The parties to this instrument agree that this note is executed as a convenient mode of evidencing the indebtedness due and, should it be incomplete in any necessary respect when executed, said parties, whether maker, indorser, surety or grantor, hereby authorize the payee herein named to complete said instrument to evidence the whole of said indebtedness.

Laws of the State of Alabama and of the United States provide that in some circumstances certain money and property may not be taken to pay certain types of Court judgments, because certain money or property may be "exempt." The parties to this instrument, whether maker, endorser, surety or grantor, each for themselves, HEREBY WAIVE AS TO THIS DEBT ALL RIGHT OF EXEMPTION AS TO PERSONAL PROPERTY authorized by the Constitution and laws of the State of Alabama or any other state and each, for himself/herself, agrees to pay all costs of collecting, securing or attempting to collect to secure the indebtedness hereby secured, including a reasonable attorney's fee, whether suit be necessary or otherwise, and all parties hereto for themselves, waive all necessity of demand, presentment, protest, notice of protest, and waive all right to require the payee or anyone having the beneficial interest in this note to bring suit thereon against the principal debtor, or against any cosurety.

Total patient charges as of 12:00 a.m. on 4/26/03 are $ Pending . Charges which have not been previously entered to this account will be added to the above balance and will appear on the final bill.

Monthly payment arrangements of equal monthly installments of $ 50.00 , beginning 5/10/03 and ending when final balance of this account has been paid in full, have been made between guarantor of this promissory note and FLORALA MEMORIAL HOSPITAL.

THE UNDERSIGNED CERTIFY WITH SIGNATURE THAT HE/SHE CAN READ THE ENGLISH LANGUAGE AND HAVE READ AND UNDERSTOOD THIS PROMISSORY NOTE AND AGREEMENT. HE/SHE FURTHER CERTIFY THAT HE/SHE IS/ARE NINETEEN YEARS OF AGE OR OLDER AND SIGN OF HIS/HER OWN FREE WILL, UNDER NO CONSTRAINT OR UNDUE INFLUENCE FROM ANY SOURCE.

Crystal [signature] ______________________ ______________________ SEAL

DRESS

______________________ ______________________ SEAL

____

entative [signature] Adams RN

PLAINTIFF'S EXHIBIT 16d

Blumberg No. 5113

FHH-72

I hereby agree and give my consent for the admission/treatment of ______________________________ (physician name ...)
FLORALA MEMORIAL HOSPITAL, hereinafter referred to as the Hospital, under the care of the attending physician, his associates, partners, assistants or designees. I consent to any and all hospital care, which encompasses radiological examinations, laboratory procedures, diagnostic procedures, anesthesia, and nursing or medical/surgical treatment which my physician, his associates, partners, assistants or designees may deem necessary or advisable, under the general and special instructions of the same, during my hospitalization.

In consideration of the hospital care and treatment to be rendered to me by the Hospital, I agree and consent to the following conditions:

(1) GENERAL DUTY NURSING. The Hospital provides only general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special duty nursing care, it is agreed that such must be arranged by the patient, or his legal representative, or his physicians, and the Hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

(2) MEDICAL AND SURGICAL TREATMENT. I agree and understand that all physicians, dentists and oral surgeons treating me or the patient in any way are responsible and liable for their own acts or omissions and the Hospital is not responsible or liable for the acts and omissions of the aforementioned. I am aware that the practice of medicine is not an exact science and further state that no guarantee has been or can be made as to the results of the treatments of examinations in the Hospital. The undersigned recognizes that all doctors of medicine furnishing services to the patient, including the radiologist, pathologist, anesthetist and the like are independent contractors and are not employees or agents of the hospital.

(3) ASSIGNMENT OF INSURANCE BENEFITS. In order to correctly process your insurance claim, the patient or responsible party is responsible for providing at the time of service, the most current address, phone number and insurance information. The undersigned hereby assigns and authorizes payment directly to the Hospital, of any hospital benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third-party, payable by any party, organization, et cetera, to or for the patient unless the account for this hospital, outpatient treatment or series of outpatient treatments is paid in full upon discharge or completion of outpatient treatments. If eligible for Medicare, the undersigned requests Medicare services and benefits.. The undersigned further agrees that this assignment will not be withdrawn or voided at any time until this account for this hospitalization is paid in full. The undersigned understands that they are responsible for any hospital charges not covered by their insurance company and individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital.

(4) PAYMENT AGREEMENT. The undersigned individually obligates himself to the payment of the Hospital account incurred by the patient in accordance with the regular rates and terms of the Hospital at the time of patient's discharge. If the patient fails to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, the undersigned shall pay all collection agency fees, court costs and attorney's fees. The undersigned agrees that any patient or guarantor overpayments collected on the above admission or outpatient treatments may be applied directly to any delinquent account for which the patient or guarantor is legally responsible at the time of collection of the overpayment.

(5) ASSIGNMENT OF PHYSICIAN BENEFITS. In the event that I, the patient, in addition to hospital benefits, am entitled to any physician(s) benefits of any type whatsoever arising out of a policy of insurance insuring me or any other party's liability to me, I hereby assign said benefits to any physician rendering care or treatment during this stay or outpatient visits, to be applied to my bill.

(6) RELEASE OF MEDICAL INFORMATION. I authorize the Hospital and any physician rendering care or treatment to release medical and supporting documentation of same as compiled in the medical records during this admission or outpatient visit for purposes of benefit payment.

(7) MEDICARE PATIENT CERTIFICATION. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized benefits be made on my behalf.

(8) PRIVATE ROOM DIFFERENCE. I agree and understand that if I request a private room for myself or the patient, I am responsible for the entire private room difference.

(9) PERSONAL VALUABLES AND BELONGINGS. It is understood and agreed that the Hospital maintains a safe for the safekeeping of money, valuables and personal belongings and the Hospital shall not be liable for the loss or damage to any articles or personal property while I am hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items.

(10) ADVANCE DIRECTIVE ACKNOWLEDGEMENT: Please read and initial the following statements:

1. I have been given written materials about my right to accept or refuse medical treatments. ______ (initial)
2. I have been informed of my rights to formulate Advance Directives. ______ (initial)
3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this facility. _____(initial)
4. I understand that the terms of any Advance Directive that I have executed will be followed by the Hospital and my caregivers to the extent permitted by law. _____ (initial).
5. **I have executed an Advance Directive _______ (initial) OR I have not executed an Advance Directive. _______ (initial)**

(11) PATIENT RIGHTS: The patient has the right to:

1. considerate and respectful care;
2. obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name the physician responsible for coordinating his care;
3. receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and/or treatment;
4. refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action;
5. every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present;
6. expect that all communications and records pertaining to his care should be treated as confidential;
7. expect that within its capacity the Hospital must make reasonable response to the request of a patient for services. The Hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer;
8. obtain information as to any relationship of the Hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects;
10. expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or delegate of the physician of the patient's continuing health care requirements following discharge;
11. examine and receive an explanation of his bill regardless of source of payment;
12. know what Hospital rules and regulations apply to his conduct as a patient.

(12) NOTICE OF PRIVACY PRACTICES: *Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA).* I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the facility may use and disclose my protected health information.

The undersigned certifies that they have read this entire document and are the patient, or are dully authorized by the patient or by the law to execute the above agreement and accepts and understands its terms.

______________________ Witness | ______________________ Patient | __________ Date

______________________ Address | ______________________ Patient's Agent/Guarantor/Relationship | __________ Date

NOTICE OF PRIVACY PRACTICES

Your rights under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

How Your Medical Information May Be Used and Disclosed and How You Can Get Access To This Information

If you have any questions about this notice, please contact the facility's Health Information Management Department.

PLEASE REVIEW CAREFULLY.

Who Will Follow This Notice:

This notice describes the facility's practices and that of:

- Any health care professional authorized to enter information into your facility chart.
- All departments and units of the facility
- Any member of a volunteer group allowed to help you while you are in the facility
- All employees, staff, agents and other facility personnel
- All entities, sites and locations within this facility's system will follow the terms of this notice. They also may share medical information with each other for treatment, payment and health care operations purposes.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your healthcare is personal. We are committed to protecting medical information about you. A record is created of the care and services you receive at this facility. This record is needed to provide the necessary care and to comply with legal requirements. This notice applies to all of the records of your care generated by the facility. Your personal physician may have different policies or notices regarding the physician's use and disclosure of your medical information in the physician's office or clinic.

This notice will tell about the ways in which the facility may use and disclose medical information about you. Also described are your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires the facility to:

- Make sure that medical information that identifies you is kept private;
- Inform you of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THE FACILITY MAY USE and DISCLOSE YOUR MEDICAL INFORMATION:

The following categories describe different ways the facility uses and discloses medical information. Each category will be explained. Not every possible use or disclosure will be listed. However, all the different ways the facility is permitted to use and disclose information will fall within one of these categories.

- Treatment. Your medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, or other agents of the facility who are involved in your care at the facility. Your medical information may also be disclosed to healthcare students, interns and residents.

For example: A doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may need to tell the dietitian about the diabetes so appropriate meals can be arranged. Different departments of the facility may also share medical information about you in order to coordinate your different needs, such as prescriptions, lab work and x-rays. The facility also may disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as family members, home health agencies, or others used to provide services that are part of your care.

- Payment. Your medical information may be used and disclosed so that the treatment and services received at the facility may be billed and payment may be collected from you, the insurance company and/or a third party.

For example: The health plan or insurance company may need information about surgery you received at the facility so they can provide payment for the surgery. Information may also be given to someone who helps pay for your care. Your health plan or insurance company may also need information about a treatment you are going to receive to obtain prior approval or to determine whether they will cover the treatment.

- Health Care Operations. Your medical information may be used and disclosed for purposes of furthering day-to-day facility operations. These uses and disclosures are necessary to run the facility and to monitor the quality of care our patients receive.

For example: Your medical information may be:

1. Reviewed to evaluate the treatment and services performed by our staff in caring for you.
2. Combined with that of other facility patients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are affective.
3. Disclosed to doctors, nurses, technicians, and other agents of the facility for review and learning purposes.
4. Disclosed to healthcare students, interns and residents.
5. Combined with information from other facilities to compare how we are doing and see where we can improve the care and services offered. Information that identifies you in this set of medical information may be removed so others may use it to study health care and health care delivery without knowing who the specific patients are.

- Census Information: Limited information about you may be used in the census report while you are a patient at the facility. This information may include your name, location in the facility, admission date and room number.

- Clergy Members: While you are a patient in the facility, upon written consent, information about you may be disclosed to your specific clergy. This information may include your name, location in the facility, admission date and room number.

ADDRESSOGRAPH

ADMISSIONS
Notice of Privacy Practices
FLORALA MEMORIAL HOSPITAL
P.O. Box 189 • 24273 Fifth Avenue • Florala, Alabama 36442
(334) 858-3287

- Appointment Reminders. Your medical information may be used to contact you as a reminder of an appointment you have for treatment or medical care at the facility.

- Treatment Alternatives. Your medical information may be used to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- Health-Related Benefits and Services. Your medical information may be used to tell you about health-related benefits or services that may be of interest to you.

- Private Accreditation Organizations. Your medical information may be used to fulfill this facility's requirements to meet the guidelines of private hospital accreditation organizations such as JCAHO, NCQA, etc.

- Individuals Involved in Your Care. With your permission, your medical information may be released to a family member, guardian or other individuals involved in your care. They may also be told about your condition unless you have requested additional restrictions. In addition, your medical information may be disclosed to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location.

- Research. Under certain circumstances, your medical information may be used and disclosed for research purposes.

For example: A research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same conditions. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, balancing the research needs with the patients' need for privacy of their medical information. Your medical information may be disclosed to people preparing to conduct a research project; for example, helping them look for patients with specific medical needs, so long as the medical information they review does not leave the facility. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the facility.

- As Required by Law. Your medical information will be disclosed when required to do so by federal, state, or local authorities, laws, rules and/or regulations.

  Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, your medical information will be disclosed in response to a court or administration order, subpoena, discovery request, or other lawful process by someone else involved in the dispute when we are legally required to respond.

  Law Enforcement. Your medical information will be released if requested by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identify, description or location of the person who committed the crime.

National Security and Intelligence Activities. Your medical information will be released to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. Your medical information may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

To Alert a Serious Threat to Health or Safety. Your medical information may be used and disclosed when necessary to prevent a serious threat to your health and safety and that of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities. Your medical information may be disclosed to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

SPECIAL SITUATIONS:

- Organ and Tissue Donation. If you are an organ or tissue donor, your medical information may be released to organizations that handle organ procurement or organ, eye and tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- Medical Devices. Your social security number and other required information will be released in accordance with federal laws and regulations to the manufacturer of any medical device(s) you have implanted or explanted during this hospitalization and to the Food and Drug Administration, if applicable. This information may be used to locate you should there be a need with regard to such medical device(s).

- Military and Veterans. If you are a member of the armed forces, your medical information may be released as required by military command authorities. If you are a member of the foreign military personnel, your medical information may be released to the appropriate foreign military authority.

- Workers' Compensation. If you seek treatment for a work-related illness or injury , we must provide full information in accordance with state-specific laws regarding workers' compensation claims. Once state-specific requirements are met and an appropriate written request is received, only the records pertaining to the work-related illness or injury may be disclosed.

ADMISSIONS
FLORALA MEMORIAL HOSPITAL
Box 189 • 24273 Fifth Avenue • Florala, Alabama 36442
(334) 858-3287

To request an amendment, your request must be in writing. You must also provide a reason that supports your request.

Your request for an amendment may be denied if:

- Your request is not in writing or does not include a reason to support the request;
- The medical information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- The medical information is not part of the medical information kept by or for the facility;
- The medical information is not part of the information you would be permitted to inspect and copy; or
- The medical information is accurate and complete.

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment and health care operations. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

To request this list or accounting of disclosures:

- You must submit your request in writing.
- Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.
- Your request should indicate in what form you want the list (for example, on paper, electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member.

For example: You could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing. In your request, you must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure or both;
- To whom you want the limits to apply, for example, disclosures to your spouse.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

For example: You can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a copy of this notice. You may ask us to give you a copy at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

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